U.S. Department of Transportation
Maritime Administration

REPORT OF ATTENDING DENTIST/PHYSICIAN

OMB Control No. 9000-0077
Public reporting burden of this collection of information is estimated to average one hour per response. Send comments regarding this burden estimate or any other aspect of this information collection to the Maritime Administration, Office of Management Services, 400 Seventh St, SW, Room 7225, Washington, DC 20590, and to the Office of Management and Budget, Paperwork Reduction Project (9000-0077), Washington, DC 20503.

Ship manager	Vessel	
Ship manager's address	**Date of injury or illness**	**Time of injury or illness**
	Person authorizing treatment	

DENTIST/PHYSICIAN/HOSPITAL/CLINIC: Please examine, diagnose, and prescribe treatment/medication to the below-named seaman. NOTE: Treatment for venereal disease and dental work other than extractions must be paid for directly by the seafarer.

Background Information

Patient's name	Social Security Number	Sex	Age
		❒ male ❒ female	

Patient's mailing address

Patient's account of how injury or exposure to occupational disease occurred

Findings and Diagnosis

Date of this visit	Time in	Time out	Is further medical attention required?	If YES, date to return
			❒ Yes ❒ No ❒ Unknown	

Was patient referred to other health care provider?	If YES, name, address and telephone number of other heath care provider
❒ Yes ❒ No	
Date treatment completed	

Findings upon examination, including results of x-rays, laboratory studies, etc. IN THE CASE OF INJURY, PLEASE COMPLETE THE REVERSE OF THIS FORM. Additional comments may be provided on blank sheets of paper.

Is diagnosed condition due to the occurrence described by the patient?	Number of visits by patient to date	Date(s) of your treatment (from/to)
❒ Yes ❒ No ❒ Unknown		

Nature of treatment

Please indicate the seafarer's current duty (work) status (check ONE)	If Not Fit for Duty/Fit for Travel, is termination of duty recommended?
❒ Fit for Duty (no restrictions)	❒ Yes ❒ No
❒ Not Fit for Duty/Fit for Travel	
❒ Not Fit for Duty/Not Fit for Travel	**If Not Fit for Duty/Not Fit for Travel, is hospitalization recommended?**
❒ Permanently Not Fit for Duty	❒ Yes ❒ No

If Permanently Not Fit for Duty, please describe nature of and degree of impairment	Has patient reached maximum medical improvement?
	❒ Yes ❒ No

Name of attending physician/dentist	Signature of attending physician/dentist	Date of this report

Address of dentist/physician/hospital/clinic	Telephone number
	FAX number

Form MA-1001F (6-94)